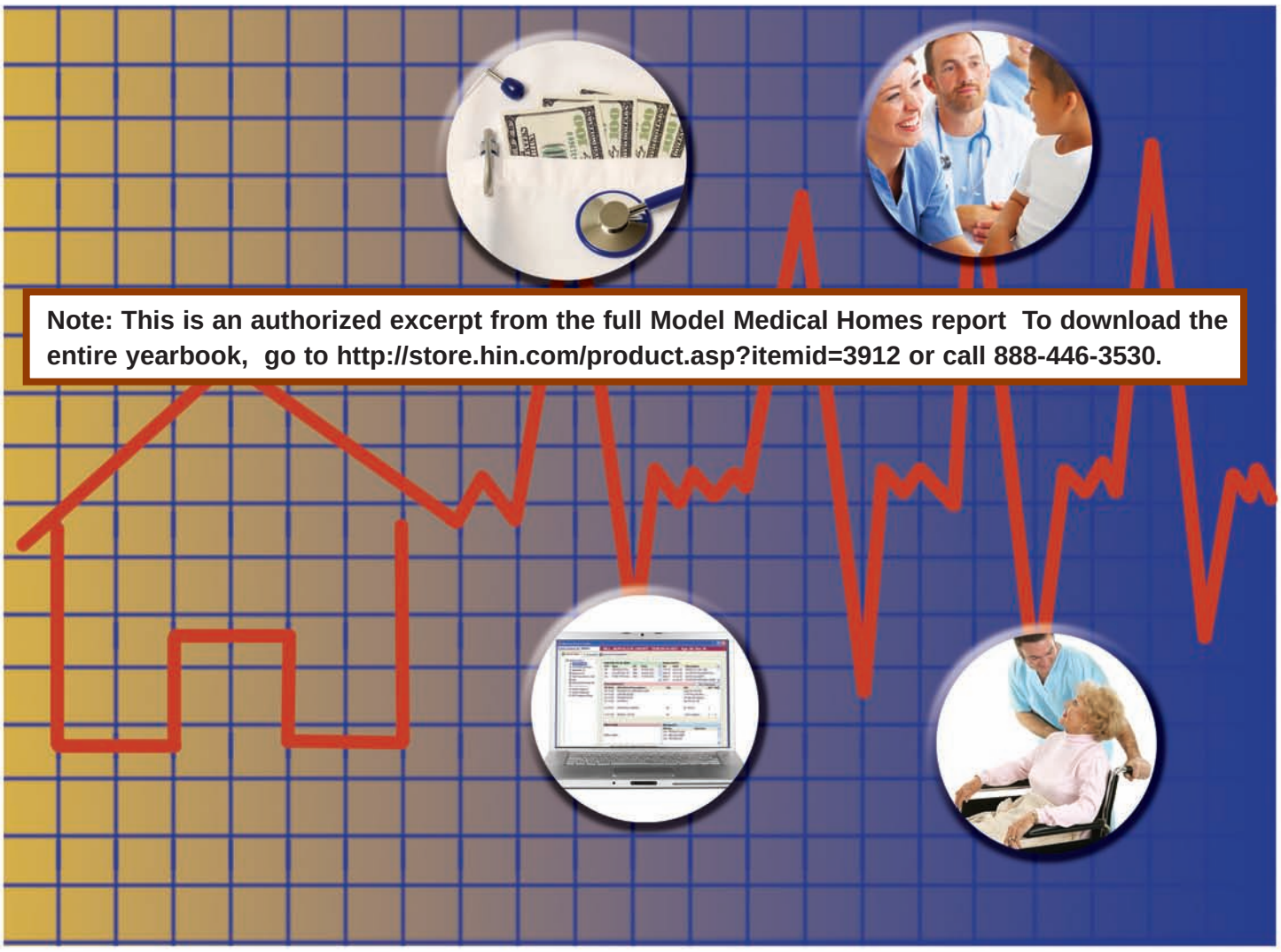
Model Medical Homes:

Benchmarks and Case Studies in Patient-Centered Care



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HIN's Benchmarks Series

Model Medical Homes: Benchmarks and Case Studies in Patient-Centered Care

This special report is based on an in-depth analysis of responses from 221 healthcare organizations to the 2009 Healthcare Intelligence Network Industry Survey, "Medical Homes in 2009," as well as in-depth interviews with selected survey respondents.

Contributors

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Table of Contents

List of Figures

2009 Industry Survey Results: The Patient-Centered Medical Home Model

The patient-centered medical home (PCMH) model of care — an approach embraced by thousands of healthcare organizations — focuses on improving care quality and reducing costs for the chronically ill. According to a 2004 report in the Annals of Family Medicine, if every American had a medical home, healthcare costs would decrease by 5.6 percent, resulting in national savings of $67 billion per year and improved care. This report summarizes the results from HIN's Medical Homes in 2009 e-survey in which more than 220 healthcare organizations described the role of the PCMH in their organizations.

Medical Home Awareness

Over 90 percent of organizations surveyed (221 respondents) are familiar with the term "medical home" (**Fig. 1**) yet only 37.8 percent of those familiar with the term had established PCMH programs for their members and/or patients (**Fig. 2**). Nearly half — 44.8 percent — of respondents without a PCMH approach do plan to establish medical homes for their members and/or patients within the next 12 months (**Fig. 3**).

According to the 61 respondents who answered this question, more than a third say 5 percent or less of their organization's members/patients have a designated PCMH (**Fig. 4**). Another third of respondents — 29.5 percent — say 21 percent or more have a PCMH. Of the 62 respondents to describe their populations, half say their PCMH programs target Medicaid beneficiaries, while 30 respondents target commercial populations, 25 respondents note they target Medicare beneficiaries, and 14 respondents note that their PCMH programs target pediatric populations (**Fig. 5**).

Nearly 39 percent of respondents with medical home efforts note that their PCMH programs cover

Figure 1: Familiarity with Medical Homes (All Respondents)

Is your organization familiar with the term "medical home"?	Response Percent
Yes	91.0%
No	9.0%

Source: Medical Homes in 2009 HIN E-Survey

Figure 2: Establishment of Medical Homes (All Respondents)

Has your organization established medical homes for members and/or patients?	Response Percent
Yes	37.8%
No	62.2%

Source: Medical Homes in 2009 HIN E-Survey

Geisinger Medical Home Pilot Treats Care Transitions As Opportunities

Geisinger Health Plan's Pennsylvania-based medical home pilot has successfully reduced hospital admissions by 20 percent and overall healthcare costs by 7 percent while improving patient satisfaction and clinical outcomes for 50,000 patients managed by 25 physician practice pilot sites.[1]

The essence of medical homes is that primary care provides the "home" for the medical care of the patient, explains Janet Tomcavage, R.N., M.S.N., vice president of health services for Geisinger Health Plan (GHP). "There's a primary leader and owner of the oversight of that member or that patient's care regardless of where the member is receiving care. Hospitals, home health agencies, nursing homes, pharmacists or local community agencies are all components of that network of care system.

"We liken the medical home model to a circle of services, with the primary care team (provider, patient, family, case manager and nurse) in the center," Tomcavage continues. "This primary care team helps the patient navigate the different parts of these services, whether they're in the hospital for a week, in a nursing home for several weeks for physical rehabilitation or in the home and we're extending services to them there."

Criteria for Participation

Before launching its medical home pilot in January 2007, GHP established several criteria for site selection. First, a physician practice had to meet the "critical membership mass" requirement of about 600 Medicare patients. However, as GHP rolled out the model to some of its smaller sites, it also accepted practices with combined populations of commercial and Medicare patients.

Figure 27: Respondent Snapshot — Geisinger Health Plan Medical Home Pilot

Organization Type	Health Plan
Medical Home Target Population	Medicare, commercial
Number of Covered Lives	35,000 Medicare, 15,000 commercial
Number of Participating Physicians	25 sites with 150 providers (includes specialists and mid-level providers)
Duration of transition	12 to 18 months
Health IT in Medical Home	EHRs, patient registries, e-visits, e-prescribing, e-mail, telemonitoring
Greatest Challenge	Lack of practice/management support
Lesson Learned	Redesign of primary care practice is important; performance feedback to providers is critical; case managers must be part of the team, embedded in the practice; team must be accountable for efficiency outcomes, transitions in care a huge opportunity

Source: Janet Tomcavage, Geisinger Health Plan

Physician engagement was also a determining factor, explains Tomcavage. "To participate, the practice had to have a physician champion who was enthusiastic and wanted to be part of redesigning primary care."

Third, the site must have received a two- or three-star rating in GHP's pay-for-performance (PFP) program in order to be considered for the program, she stated.

GHP also encourages the sites to pursue NCQA medical home certification. "That's one of our quality metrics," says Tomcavage. "Obviously, we want the practices to ultimately achieve level three NCQA certification. But in the first year, we just wanted the sites to at least submit the application and receive some level of certification.

1 R.A. Paulus. K. Davis, and G.D. Steele, Continuous Innovation in Health Care: Implications of the Geisinger Experience, *Health Affairs*, Sept./Oct. 2008 27(5):1235?45.